Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-11-0820-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LIBERTY MUTUAL FIRE INSURANCE Box #: 01	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: A position summary was not submitted.

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $653.45

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The continued prescription medications being obtained for this 2001 injury have been denied as not medically necessary due to the determination of a RME. We have no current medical records on file for this injury. The adjuster has discussed the prescription medication with the claimant and is sending a letter to the claimant regarding the request for reimbursement."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
01/08/2010 thru 10/20/2010	No EOBs submitted	Out-of-Pocket expenses – Prescription Medication	$653.45	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. In accordance with Texas Admin Code Section §133.307(c)(3) an employee who has paid for health care may request medical fee dispute resolution of a reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal deliver or facsimile and shall include: (A) the form DWC-60 table listing the specific disputed health care in the form and manner prescribed by the Division; (B) an explanation of the disputed amount that includes a description of the health care, why the disputed amount should be reimbursed and how the submitted documentation supports the explanation for each disputed amount; (C) Poof of employee payment (including copies of receipts, provider billing statements, or similar documents); and (D) a copy of the carrier's denial of reimbursement relevant to the dispute, or if no denial was received convincing evidence of the employee's attempt to obtain reimbursement from the carrier. The information submitted to Medical Fee Dispute Resolution did not

contain convincing evidence that a request for reimbursement was made in accordance with 28 Texas Admin Code Section §133.270.

2. Additionally, the Respondents position summary the injured workers use of the medication in dispute is not medically necessary. According to 28 Texas Admin Code Section §133.307(d)(2)(B) the response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity the request for MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section. In accordance with 28 Texas Admin. Code Section §133.305(a)(10) Retrospective medical necessity dispute--A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this subchapter and (b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021. The Requestor is hereby notified that the submitted dispute was submitted to the incorrect dispute sequence.

3. In conclusion, according to 28 Texas Admin. Code §§ 133.305 and 133.307 the medical necessity issue raised by the insurance carrier is not eligible for review at Medical Fee Dispute Resolution. Therefore the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	12/29/2010 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.